

**BEFORE THE APPEALS BOARD  
FOR THE  
KANSAS DIVISION OF WORKERS COMPENSATION**

**TROY J. MOODY**

Claimant

V.

**KBW OIL & GAS COMPANY**

Respondent

AND

**AMERICAN INTERSTATE INS. CO.**

Insurance Carrier

Docket No. 1,061,663

**ORDER**

Respondent and its insurance carrier (respondent) request review of Special Administrative Law Judge (SALJ) Jerry Shelor's December 10, 2013 Award. W. Walter Craig of Derby, Kansas, appeared for claimant. Terry J. Torline of Wichita, Kansas, appeared for respondent. The Board heard oral argument on April 8, 2014.

The Board has considered the record and adopted the stipulations listed in the Award. In a Stipulation dated September 20, 2013, the parties offered into evidence records from Dr. Bliss, along with Dr. Prostic's August 12, 2013 report. The parties stipulated that Dr. Prostic opined claimant had a 20% preexisting whole body impairment based on lumbar involvement and a 20% preexisting whole body impairment based on cervical spine involvement for a combined preexisting whole body rating of 36%, as based on the *AMA Guides*<sup>1</sup> (hereinafter *Guides*). The parties agreed respondent is entitled to credits for having advanced \$8,325 in permanent partial disability benefits and retirement benefits in the amount of \$1,018.81.

The parties agreed the Board may consult the *Guides* and the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, if necessary, and consider the June 3, 2013 preliminary hearing exhibits, except for such exhibits that contain medical opinions which lack the supporting testimony of a health care provider.

The parties also noted at oral argument that claimant is currently receiving treatment from Eric Clarkson, D.O., and Michael Leahy, Psy.D., a clinical psychologist and psychotherapist, as based on a preliminary hearing Order.

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<sup>1</sup> American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed.). All references are based upon the fourth edition of the *Guides* unless otherwise noted. Under the *Guides*, adding and combining impairments are different functions. A combined rating is derived from the Combined Values Chart starting on page 322 of the *Guides*. An example shows a 35% impairment combined with a 20% impairment results in a 48% impairment (not added to get 55%). In this case, a 20% impairment combined with a 20% equals 36% impairment, not a 40% impairment.

### ISSUES

A moving part of an oil well struck claimant while he was working on September 23, 2011. The SALJ found claimant had a 43% whole body impairment based on splitting Dr. Harris' and Dr. Murati's ratings and determined claimant was permanently and totally disabled.

Respondent argues claimant's psychological problems are not compensable. Respondent argues a split of the ratings improperly includes what it considers non-compensable injuries (i.e., psychological impairment, carpal tunnel syndrome (CTS) impairment, etc.). Respondent argues claimant's evidence of permanent total disability is wrongly based on claimant's preexisting psychological problems and multiple prior spine surgeries. Respondent asserts the Award should be reduced by what it calculates to be claimant's preexisting 39% whole body impairment, including a 20% lumbar spine impairment, a 20% cervical spine impairment and a 5% psychological impairment.

Claimant maintains the Award should be affirmed without any deduction for preexisting impairment because the 2011 injuries are separate and distinct from any preexisting impairments and the accident is the prevailing factor in causing his injuries, medical conditions and resulting disability and impairments. Claimant argues he is permanently and totally disabled.

The issues on appeal are:

1. Is claimant's psychological condition compensable, including:
  - A. did claimant's injury solely aggravate, accelerate or exacerbate a preexisting condition or render a preexisting condition symptomatic?
  - B. was claimant's accident the prevailing factor in causing his injury and medical condition?
  - C. did claimant suffer a traumatic neurosis directly traceable to his physical injury?
  - D. are Dr. Leahy's opinions reliable?
2. What is the nature and extent of claimant's disability, including respondent's entitlement to a deduction for preexisting impairment?
3. Is claimant entitled to future medical treatment?

### FINDINGS OF FACT

Claimant sustained a skull fracture, a jaw fracture and a traumatic brain injury (TBI), as well as neck, left shoulder, left clavicle and teeth injuries in his 2011 accidental injury. He had neck and shoulder surgeries. Claimant questions if he will be able to keep his bottom teeth. He alleged low back complaints. Claimant further asserted mental health issues and cognitive deficit, including difficulty with everyday tasks, anxiety, nightmares of his accident, impaired memory and forgetfulness. Claimant now takes anxiety medication. Due to difficulty balancing his checkbook, claimant assigned such task to his adult children. Claimant's son, Weston, testified that after the accident, he noticed his father having memory issues and difficulty lifting anything with his left arm. Claimant currently lives alone and is able to drive and perform activities of daily living unassisted.

The dispute in this case largely revolves around claimant's preexisting conditions, which respondent alleges to be depression, anxiety, stress, insomnia and chronic pain due to prior lumbar and cervical spine injuries and surgeries. We will discuss claimant's prior problems before revisiting the 2011 injuries in more detail.

Claimant was at Green Oaks Hospital a total of two days for alcohol detoxification, probably in 1993 or 1994. At some indeterminate point prior to October 1998, claimant saw a psychiatrist, Dr. Montgomery, a couple times concerning marital issues.

Claimant had an October 15, 1998 work-related low back injury that resulted in an L4-S1 fusion on April 1, 1999, under the direction of Ian S. Kovach, M.D. Dr. Kovach opined claimant was depressed, at least partly due to his surgery. Claimant had more mental health treatment with Dr. Montgomery.

Claimant separated from his wife on May 1, 1999. Claimant saw Gary Schnoebelen, a psychologist, for a one-time evaluation prior to admittance to Valley Hope for depression and alcohol abuse treatment, apparently in July 1999. Bill Rainwater counseled claimant at Valley Hope, where claimant had inpatient and outpatient treatment.

Mitchel A. Woltersdorf, Ph.D., a psychologist, evaluated claimant on July 13, 1999. Dr. Woltersdorf noted claimant's statement that he went to Valley Hope to "better understand stress."<sup>2</sup> Claimant complained of headaches, anger and mood control problems/emotional lability, disturbed sleep, reduced appetite, libido and initiative, social isolation and episodic confusion. Claimant had been taking Effexor and Klonopin for about one month. Dr. Woltersdorf concluded claimant's low back injury likely caused a mild aggravation of premorbid depression, in spite of claimant's dysfunctional home life and his difficulties with stress.

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<sup>2</sup> R.H. Trans., Resp. Ex. 3 (Dr. Woltersdorf's July 13, 1999 report at 1).

On September 9, 1999, 12 years before the accident at hand, a preliminary hearing was held in which claimant sought psychological counseling in connection with his 1998 low back injury. Regarding his prior mental health issues, claimant testified he had family and marital problems based on his wife's hospitalizations due to depression, as well as his own alcohol issue and depression.<sup>3</sup> Despite these prior problems with marital issues and alcohol use, claimant testified at the 1999 hearing that he was "fine"<sup>4</sup> before his 1998 low back injury and he denied taking any psychotropic medication before the 1998 injury.<sup>5</sup>

Following the 1999 preliminary hearing, Judge Nelsonna Potts Barnes ordered psychological counseling for an aggravation of preexisting depression.

On January 3, 2000, claimant was seen by Pedro Murati, M.D., who is board certified in electrodiagnostic medicine and physical medicine and rehabilitation. Dr. Murati provided claimant a 25% whole body rating under the *Guides* based on DRE Lumbosacral Category V and diagnosed him with clinical depression. Dr. Murati also assigned claimant with permanent light duty restrictions, including occasional lifting of up to 20 pounds.

As a result of claimant's accidental low back injury, the Board determined claimant sustained a 20% whole body functional impairment, but with 5% being preexisting, resulting in a March 26, 2001 Award of a 15% whole body impairment.<sup>6</sup>

Claimant had a second lumbar surgery, a discectomy, in 2003.

Claimant treated with Kirk Bliss, D.O. Dr. Bliss' March 8, 2006 chart note, shows claimant reported chronic back pain and obtained a medication refill for OxyContin, which was refilled again on May 12, 2006. On August 11, 2008, claimant was seen by Dr. Bliss for a recheck of his laboratory work and complaints of low back pain. Dr. Bliss diagnosed claimant with chronic back pain, arthralgias and fatigue. Dr. Bliss prescribed Cymbalta. Such record also listed Ambien as one of claimant's medications.

A September 15, 2008 phone note in Dr. Bliss' records stated:

PC TO JEFF FOR PRIOR AUTH OF CYMBALTA. PT HAS TRIED WELLBUTRIN, PAXIL AND ZOLOFT. PER JEFF APPROVED FOR DEPRESSION AND ARTHRALGIAS/BACK PAIN.<sup>7</sup>

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<sup>3</sup> *Id.*, Resp. Ex. 3 at 8-9.

<sup>4</sup> *Id.*, Resp. Ex. 3 at 9.

<sup>5</sup> *Id.*, Resp. Ex. 3 (Dr. Woltersdorf's July 13, 1999 report at 1).

<sup>6</sup> *Id.*, Resp. Ex. 1 at 3.

<sup>7</sup> We do not know the identity, occupation or role of "Jeff."

A January 15, 2009 phone note indicated claimant did not think Cymbalta was working for his joint pain.

Claimant returned to Dr. Bliss on April 14, 2009 and was prescribed Feldene for chronic low back pain. Claimant was prescribed Robaxin. Flexeril and Amrix were prescribed in April, May and June 2009.

In 2009, claimant suffered a vocationally-related neck injury while working for an unrelated employer. Claimant did not report this accident within 10 days and received no workers compensation benefits.

Dr. Bliss prescribed claimant Percocet on November 24, 2009, and arranged for a CT myelogram of his lumbar spine. Claimant's Percocet was refilled in early-2010. Claimant had two unsuccessful cervical spine epidural steroid injections in early-2010.

On March 8, 2010, Dr. Bliss noted claimant was under a lot of stress due to chronic spine problems, including being scheduled for an upcoming cervical spine fusion. Claimant had a C5-7 fusion on March 16, 2010. Dr. Bliss prescribed claimant Ambien in March and April 2010.

On July 20, 2010, Dr. Bliss recorded that claimant had chronic neck pain and right arm paresthesias. After claimant reported trouble sleeping, Dr. Bliss switched his medication from Ambien to amitriptyline. As of February 28, 2011, claimant's low back was reported as being relatively well, but his neck would bother him off and on. Dr. Bliss noted claimant had cervical spine muscle spasm and he prescribed Neurontin and Robaxin.

At no time between March 8, 2006 and February 28, 2011, did Dr. Bliss provide claimant with a mental health diagnosis such as depression or generalized anxiety disorder. Dr. Bliss also did not diagnose claimant with insomnia.

It appears Eric Clarkson, D.O., suggested claimant obtain therapy in 2012.<sup>8</sup> From May 24, 2012 forward, claimant received psychological treatment from Michael Leahy, Psy.D. Dr. Leahy noted claimant was anxious, depressed, angry and labile, with lessened awareness, disorganized thoughts, as well as having insomnia. Dr. Leahy initially diagnosed claimant with depression and posttraumatic stress disorder.

On January 3, 2013, claimant was evaluated at respondent's request by David E. Harris, D.O., who specializes in physical medicine and rehabilitation, including pain management. Dr. Harris reviewed 575 pages of medical records and examined claimant. Dr. Harris reported claimant made progress over the previous six months to one year, was living alone and no longer required supervision from his son.

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<sup>8</sup> See Murati Depo., Ex. 2 at 5.

Dr. Harris did not provide an opinion regarding permanent work restrictions, but gave claimant an overall 30% whole body impairment consisting of:

- a 15% new whole body impairment for his cervical spine, above and beyond preexisting cervical spine impairment;
- a 10% left upper extremity impairment for his left brachial plexus;
- a 13% impairment to the left upper extremity at the level of the shoulder; and
- a 5% whole body impairment for residuals of a TBI, including minimal difficulty with multitasking, short-term memory, organization and mood/emotional disorders, including anxiety and what claimant termed PTSD. The 5% whole body rating for the head injury consisted of 3% for mental status impairment and 2% for emotional and behavioral impairment.<sup>9</sup>

On January 29, 2013, claimant was seen at his attorney's request by Dr. Murati. Dr. Murati provided claimant with 15 diagnoses, including:

1. status post closed head injury with sequelae;
2. trigeminal neuropathy;
3. status post, placement of right-sided intracranial pressure monitor, right subclavian central venous line and right radial arterial line;
4. status post, open reduction and internal fixation of symphyseal fracture with Lorenz plates and application for arch bars;
5. status post 7 cm linear laceration of his left forehead;
6. status post, left triceps branch of the radial nerve to anterior branch of axillary nerve transfer;
7. status post, C4-C5 anterior cervical discectomy and fusion, with removal of anterior cervical hardware at C5, C6 and C7;
8. bilateral CTS;
9. posttraumatic stress disorder and clinical depression;
10. vestibular disorder;
11. heterotopic ossification of the left SC joint;
12. mild expressive aphasia;
13. low back pain with signs of radiculopathy, preexisting;
14. bilateral SI dysfunction; and
15. brachial plexopathy.

Dr. Murati opined all of claimant's diagnoses, except for no. 13, directly resulted from the 2011 work-related injury.

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<sup>9</sup> Dr. Harris opted not to label claimant's impairment a neurosis or psychiatric component ("Q. Now, you did provide an impairment of function associated with what I want to call his neurosis or psychiatric component; is that true? A. I would call it more the sequelae or residual from the traumatic brain injury."). (Harris Depo. at 19; see also pp. 38-39)).

Dr. Murati assigned a 56% whole body impairment consisting of:

- 6% whole person or 10% right upper extremity for right CTS;
  - 21% whole person or 52% left upper extremity, consisting of 10% to the left upper extremity for CTS, 15% to the left upper extremity at the level of the shoulder for decreased range of motion, and 38% to the left upper extremity for loss of axillary nerve, presumably at the level of the shoulder;
  - 5% whole person for vestibular disorder;
  - 3% whole person for trigeminal neuropathy;
  - 5% whole person for difficulty with mastication (chewing);
  - 25% whole person for neck pain status post fusion; and
  - 14% whole person for status post closed head injury with sequelae.
- In addressing prevailing factor, Dr. Murati's report stated:

The claimant sustained an accident at work which resulted in bilateral upper extremity pain, neck pain, upper back pain, low back pain, and a head injury. He is a young person. He is a nonsmoker. His hobbies are not known as a direct cause for his current diagnoses. He does have significant pre-existing injuries regarding his low back and neck, however his continuing neck and low back symptoms were controlled prior to this work related injury and he was in his normal state of health and able to perform his job duties. He has significant clinical findings that have given him diagnoses consistent with his described accident at work. Therefore, it is under all reasonable medical certainty and probability, the prevailing factor in the development of his conditions is the accident at work.<sup>10</sup>

Dr. Murati provided permanent restrictions of no bending, crouching, stooping, ladders, or crawling; rarely stairs and squatting; occasional sitting, standing, walking and driving; occasional right repetitive grasp and frequent right repetitive hand controls; no work more than 18 inches away on the left; avoid awkward positions of the neck; use wrist splints while working and at home bilaterally; alternate sitting, standing and walking; avoid trunk twisting; no use of hooks or knives; no keyboarding or vibratory tools with both upper extremities; no lifting, carrying, pushing or pulling above 10 pounds; occasional lifting, carrying, pushing or pulling up to 5 pounds; and frequent lifting, carrying, pushing or pulling up to 2.5 pounds. Dr. Murati recommended at least yearly follow-ups on his neck, upper back, low back, bilateral upper extremities and head. Dr. Murati opined claimant is essentially and realistically unemployable and permanently and totally disabled.<sup>11</sup>

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<sup>10</sup> Murati Depo., Ex. 2 at 11; see also *Id.* at 31-32.

<sup>11</sup> *Id.* at 35, 53.

Dr. Murati testified claimant's CTS was based on "double crush syndrome"<sup>12</sup> stemming from his neck injury. While Dr. Murati acknowledged that perhaps as many as 20 other physicians, including upper extremity specialists, who evaluated claimant in connection with this claim did not diagnose claimant with CTS and an EMG/NCT test did not show CTS, it was his opinion claimant had CTS on the day that he examined him.

Dr. Murati testified that while there was damage to claimant's C4 through C7 area, he only rated new impairment at C4-5 because the other two levels involved removal of hardware from a previous neck surgery.<sup>13</sup>

Dr. Murati testified he does not provide impairment ratings for psychological injuries because he lacks expertise. Dr. Murati was unaware claimant had received treatment and medication for depression prior to September 23, 2011. When presented with the possibility that claimant had prior psychological treatment, Dr. Murati testified, "Excellent, so let's just say there was an aggravation there."<sup>14</sup>

While Dr. Murati was presented with Mr. Hardin's task list, the doctor did not identify what tasks the claimant was unable to perform as a result of the September 23, 2011 accidental injury, instead indicating claimant was permanently and totally disabled.<sup>15</sup>

Dr. Harris opined in a July 19, 2013 letter that claimant was not permanently and totally disabled and stated:

[I]t is my opinion that he did suffer some relatively severe injuries that left him with (as of January 3, 2013) pain in the neck, cervical scapular junction, headaches, and left shoulder areas. Mr. Moody also complained of some disruption of his sleep and anxiety in social situations and difficulty multitasking as a result of his injuries. As a result of Mr. Moody's permanent injuries and the permanent impairments that I gave him, there is no doubt that he will have some decreased employability and decreased ability to do certain tasks and jobs. However, it is my opinion that Mr. Moody will retain the capacity to do certain tasks and may actually thrive as a result of the therapeutic benefit of responsibility and gainful employment. Given his injuries and persistent pain, I doubt that Mr. Moody will likely be able to do many manual labor job tasks. However, I do not see any reason that he would not be able to work independently in certain light duty tasks such as video security surveillance monitor where he would be able to primarily have a seated job monitoring video screen banks. He could probably do such tasks as meter reader for utility

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<sup>12</sup> *Id.* at 42.

<sup>13</sup> *Id.* at 47.

<sup>14</sup> *Id.* at 50.

<sup>15</sup> *Id.* at 35, 53.

companies as he did not retain great deficits in his lower extremities or his ability to walk per my recollection. There is the possibility that he could perform other light duty tasks such as a hotel clerk or other customer service activities in a light duty capacity, although there is some concern with his anxiety that this may require further treatment before he is able to perform these specific job tasks.

In short, I do not feel that Mr. Moody's condition is compatible with the definition of permanent total disability: a condition which renders an individual completely and permanently incapable of engaging in any type of substantial and gainful employment. I do not feel that Mr. Moody is so drastically injured that he could not maintain some degree of employability such as within job tasks similar to those described above. This opinion is expressed with a reasonable degree of medical probability.<sup>16</sup>

Dr. Harris testified he was unaware claimant was depressed, suffering from insomnia or taking medication before the accident. He noted if claimant was taking Wellbutrin before the accident, it would suggest prior anxiety or depression, if claimant was taking amitriptyline before his accident, such fact would suggest potential preexisting depression, nerve pain or insomnia, and if claimant was taking Percocet before his accident, such fact would suggest he had preexisting pain syndrome.

Dr. Harris testified claimant did not report having been diagnosed with or treated for depression, insomnia, anxiety or stress prior to September 23, 2011. Dr. Harris could not recall whether claimant reported treatment with Dr. Montgomery, Dr. Schnobelen and Mr. Rainwater. Dr. Harris could not say whether claimant's prior depression was in records he reviewed, just that any such history was neither listed in his report nor given to him by claimant. Dr. Harris did not know Dr. Leahy and he did not have Dr. Leahy's records.

Dr. Harris acknowledged it would be difficult or impossible to determine if the 2011 accident was the prevailing factor in causing claimant's injury, medical condition, and resulting disability or impairment, and he could not provide a prevailing factor opinion or determine if claimant sustained a new injury or a simple aggravation of a preexisting condition, without knowing if claimant had preexisting depression, insomnia or anxiety. However, Dr. Harris acknowledged issues of psychiatry are outside of his expertise.<sup>17</sup>

On August 1, 2013, Dr. Leahy prepared a report that stated, in pertinent part:

I'm responding to your request to comment on Mr. Troy Moody's current and proximate psychological status. I have been treating Mr. Moody over the past fourteen months.

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<sup>16</sup> Harris Depo., Ex. 3 at 1-2.

<sup>17</sup> *Id.* at 38.

From work with Mr. Moody I'm familiar he had mood and alcohol abuse concerns at an earlier time in his life related to the stress of a difficult divorce process. Nevertheless, Mr. Moody's current mood, anxiety, and cognitive dysfunction are clearly a direct residual effect of his occupational accident in September of 2011. These symptoms are a byproduct of physical impairment, chronic pain, cognitive impairment, economic hardship and social loss.

I anticipate in any proximate future Mr. Moody will continue to suffer from these residual effects to a significant level that will require psychiatric medicine regimens and supportive therapy.<sup>18</sup>

Dr. Leahy testified he did not conduct any standardized psychological testing because his role was as claimant's therapist. Dr. Leahy was aware claimant received psychological treatment in the late-1990s and early-2000s for alcohol abuse, depression, marital counseling and chronic pain, but had no knowledge of any treatment in the early-1990s. Dr. Leahy was not provided claimant's prior psychological records, but acknowledged if claimant previously took Effexor, Klonopin and Wellbutrin, it would suggest preexisting depression and anxiety. While Dr. Leahy did not have Dr. Bliss' records suggesting claimant had pre-injury chronic pain, he agreed claimant suffered from chronic pain before his 2011 accidental injury. He also agreed Dr. Bliss' records suggested claimant was having problems sleeping before September 23, 2011.

Regarding causation, Dr. Leahy testified as follows:

Q. What . . . I'm asking you here today is, do you have an opinion within a reasonable degree of medical certainty as to whether Mr. Moody's current need for ongoing medical care and the medical care you've provided to date is a direct and proximate result or cause from the work-related injuries he sustained on September the 23rd of 2011?

A. I'd have to answer that in two ways. Yes, I have a clear opinion about it, I can't say it's medical certainty, I'm not a physician.

Q. Okay. What is your opinion with regard to your opinion as to whether his current psychological needs are a direct result of the work-related injuries that occurred on September 23rd, 2011?

MR. TORLINE: I'll raise an objection, lack of qualification, as well as lack of foundation. You may answer.

Q. Go ahead and answer.

A. I feel clearly that the trauma from his work accident is the prevailing factor in his current psychological status and psychological difficulties.

. . .

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<sup>18</sup> Leahy Depo., Ex. 2 at 1.

- Q. The fact that he had some pre-existing treatment, is that indicative - - or do you have an opinion as to whether this particular injury is the current and proximate prevailing factor as to his ongoing need for psychological treatment?
- A. Yes, I believe as you phrased it, that his current - - it is the prevailing dominant factor.<sup>19</sup>

Dr. Leahy noted that his impressions of claimant were “very clear” based on having seen claimant for 17 hours over a 16 month time period.<sup>20</sup> Dr. Leahy testified that in addition to claimant’s TBI, claimant had chronic pain:

[V]ery common residual effects of chronic pain are emotional destabilization, depression, anxiety, irritability. He suffers from tremendous social loss, he’s lost his social network, he’s lost his economic stability, he’s lost his health, his ability to be independent and function independently. He’s lost the ability to sleep and get stable, restful sleep. For over two years he’s averaged four to five hours of sleep at best. Chronic sleep deprivation again generates all kinds of emotional sequelae, irritability, in fact it’s very common that long-term chronic sleep deprivation creates thought disorders, psychotic symptomatology.<sup>21</sup>

While he had never provided a rating before, Dr. Leahy, using materials from the *Guides* supplied to him by claimant’s attorney, provided claimant with a 10% whole body rating for cognitive impairment and a 20% whole body rating for emotional/behavioral impairment. He testified claimant will need psychiatric medicine and psychiatric overview the rest of his life, in addition to episodic psychological support therapy.

Claimant was seen at respondent’s request by Edward Prostic, M.D., an orthopedic surgeon, to determine his preexisting impairment. Dr. Prostic noted C. Reiff Brown, M.D., previously rated claimant at 20% whole body impairment due to a lumbar injury.<sup>22</sup> Dr. Prostic rated claimant at 20% to the body as a whole for his cervical spine impairment, which predated claimant’s 2011 work injury, and had caused continuing bilateral neurologic symptoms, including persistent sensory difficulties with his thumbs, index and long fingers. Dr. Prostic noted claimant had preexisting emotional difficulties and treatment for depression, but he could not rate claimant’s prior depression.

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<sup>19</sup> *Id.* at 6-8.

<sup>20</sup> *Id.* at 20.

<sup>21</sup> *Id.* at 8-9.

<sup>22</sup> September 20, 2013 Stipulation (Dr. Prostic’s August 12, 2013 report). The Board views Dr. Prostic’s August 12, 2013 report as reciting Dr. Brown’s opinion as to claimant’s preexisting lumbar impairment, but it does not set forth Dr. Prostic’s own opinion. Dr. Brown did not testify and his opinion is not properly in evidence pursuant to K.S.A. 44-519. Still, the Board will not disturb the parties’ stipulation regarding claimant’s preexisting impairment.

On August 26, 2013, claimant was evaluated by James G. Henderson, M.D., on behalf of Disability Determination Services. Such report will be referenced as necessary.

Two vocational experts provided opinions. Claimant's hired expert, Paul Hardin, a vocational consultant, identified tasks claimant performed in the five years before the September 23, 2011 accident. Based on Drs. Harris' and Murati's January 2013 reports, Mr. Hardin opined claimant is essentially and realistically unemployable and should be on social security disability. Karen Terrill, a rehabilitation consultant, prepared a report dated September 7, 2013 at respondent's request. Ms. Terrill did not meet with claimant, but reviewed the depositions of Dr. Harris and Paul Hardin. She opined claimant can work as a custodian, customer service person, hotel desk clerk, meter reader, surveillance system monitor, dishwasher and hand-packager.

Regarding claimant's psychological allegations, SALJ Shelor adopted the following analysis from a single Board Member's November 18, 2013 preliminary hearing Order:

Dr. Leahy indicated the accident was the prevailing factor causing claimant's injury, medical condition, and resulting disability or impairment. Respondent's medical expert, Dr. [Harris], who is neither a psychologist, psychiatrist or mental health expert, testified that he could not state that the prevailing factor in claimant's condition was the accident. Dr. McDaniel[s] report certainly raises concerns, but based on the facts and current evidence, this Board Member gives more weight to the opinion from Dr. Leahy based on his multiple evaluations of claimant over an extended period of time.

While Dr. Leahy did not simply pull "magic words" from the *Love* case and clearly state claimant's traumatic neurosis was directly traceable to his physical injury or injuries, the same result follows. It is sufficient that Dr. Leahy indicated in his report that claimant's psychological symptoms were the "direct residual effect" of the September 23, 2011 accident, which resulted in physical impairment and chronic pain. Dr. Leahy also agreed that claimant's injury was the "proximate prevailing factor" or "dominant factor" in claimant's need for psychological treatment.

Claimant certainly had prior depression and chronic pain. While medical evidence is not absolutely necessary to prove a sole aggravation, acceleration or exacerbation of a preexisting condition or that a preexisting condition was rendered symptomatic, expert medical testimony would have been helpful. The record contains no testimony that claimant's injury or injuries "solely" aggravated, accelerated or exacerbated a preexisting condition or rendered a preexisting condition symptomatic. While claimant acknowledged prior depression and pain, there is insufficient evidence to support respondent's argument advanced under K.S.A. 2011 Supp. 44-508(f)(2). Moreover, the evidence tends to show claimant's traumatic brain injury resulted in more than just depression, but also caused cognitive impairment that was not preexisting.<sup>23</sup>

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<sup>23</sup> *Moody v. KBW Oil & Gas Co.*, No. 1,061,663, 2013 WL 6382913 (Kan. WCAB Nov. 18, 2013).

SALJ Shelor, citing the version of the permanent total disability statute that preceded K.S.A. 2011 Supp. 44-510c(a)(2), found claimant to be permanently and totally disabled due to “chronic pain, unlikelihood of being employable, a 43% whole body impairment, and effects of a closed head injury.”<sup>24</sup> Respondent timely appealed.

#### **PRINCIPLES OF LAW**

K.S.A. 2011 Supp. 44-501 provides, in part:

(e) An award of compensation for permanent partial impairment, work disability, or permanent total disability shall be reduced by the amount of functional impairment determined to be preexisting. Any such reduction shall not apply to temporary total disability, nor shall it apply to compensation for medical treatment.

(1) Where workers compensation benefits have previously been awarded through settlement or judicial or administrative determination in Kansas, the percentage basis of the prior settlement or award shall conclusively establish the amount of functional impairment determined to be preexisting. Where workers compensation benefits have not previously been awarded through settlement or judicial or administrative determination in Kansas, the amount of preexisting functional impairment shall be established by competent evidence.

(2) In all cases, the applicable reduction shall be calculated as follows:

(A) If the preexisting impairment is the result of injury sustained while working for the employer against whom workers compensation benefits are currently being sought, any award of compensation shall be reduced by the current dollar value attributable under the workers compensation act to the percentage of functional impairment determined to be preexisting. The "current dollar value" shall be calculated by multiplying the percentage of preexisting impairment by the compensation rate in effect on the date of the accident or injury against which the reduction will be applied.

(B) In all other cases, the employer against whom benefits are currently being sought shall be entitled to a credit for the percentage of preexisting impairment.

(f) If the employee receives, whether periodically or by lump sum, retirement benefits under the federal social security act or retirement benefits from any other retirement system, program, policy or plan which is provided by the employer against which the claim is being made, any compensation benefit payments which the employee is eligible to receive under the workers compensation act for such claim shall be reduced by the weekly equivalent amount of the total amount of all such retirement benefits, less any portion of any such retirement benefit, other than retirement benefits under the federal social security act, that is attributable to payments or contributions made by the employee, but in no event shall the workers

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<sup>24</sup> Award at 5.

compensation benefit be less than the workers compensation benefit payable for the employee's percentage of functional impairment. Where the employee elects to take retirement benefits in a lump sum, the lump sum payment shall be amortized at the rate of 4% per year over the employee's life expectancy to determine the weekly equivalent value of the benefits.

Respondent has the burden of proving the amount of preexisting impairment to be deducted based upon the *Guides*.<sup>25</sup>

K.S.A. 2011 Supp. 44-501b(c) states:

The burden of proof shall be on the claimant to establish the claimant's right to an award of compensation and to prove the various conditions on which the claimant's right depends. In determining whether the claimant has satisfied this burden of proof, the trier of fact shall consider the whole record.

K.S.A. 2011 Supp. 44-508 states, in relevant part:

(d) "Accident" means an undesigned, sudden and unexpected traumatic event, usually of an afflictive or unfortunate nature and often, but not necessarily, accompanied by a manifestation of force. An accident shall be identifiable by time and place of occurrence, produce at the time symptoms of an injury, and occur during a single work shift. The accident must be the prevailing factor in causing the injury. "Accident" shall in no case be construed to include repetitive trauma in any form.

...

(f)(2) An injury is compensable only if it arises out of and in the course of employment. An injury is not compensable because work was a triggering or precipitating factor. An injury is not compensable solely because it aggravates, accelerates or exacerbates a preexisting condition or renders a preexisting condition symptomatic.

...

(B) An injury by accident shall be deemed to arise out of employment only if:

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<sup>25</sup> *Hanson v. Logan U.S.D.* 326, 28 Kan. App. 2d 92, 95, 11 P.3d 1184 (2000), *rev. denied* 270 Kan. 898 (2001); see also *Criswell v. U.S.D.* 497, No. 104,517, 2011 WL 5526549 (Kansas Court of Appeals unpublished opinion filed Nov. 10, 2011), *rev. denied* 296 Kan. \_\_\_\_ (2013).

(ii) the accident is the prevailing factor causing the injury, medical condition, and resulting disability or impairment.

. . .

(g) "Prevailing" as it relates to the term "factor" means the primary factor, in relation to any other factor. In determining what constitutes the "prevailing factor" in a given case, the administrative law judge shall consider all relevant evidence submitted by the parties.

(h) "Burden of proof" means the burden of a party to persuade the trier of facts by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record unless a higher burden of proof is specifically required by this act.

K.S.A. 2011 Supp. 44-510c(a)(2) provides:

Permanent total disability exists when the employee, on account of the injury, has been rendered completely and permanently incapable of engaging in any type of substantial and gainful employment. Expert evidence shall be required to prove permanent total disability.

K.S.A. 2011 Supp. 44-510h(e) states:

It is presumed that the employer's obligation to provide the services of a health care provider, and such medical, surgical and hospital treatment . . . shall terminate upon the employee reaching maximum medical improvement. Such presumption may be overcome with medical evidence that it is more probably true than not that additional medical treatment will be necessary after such time as the employee reaches maximum medical improvement. The term "medical treatment" as used in this subsection (e) means only that treatment provided or prescribed by a licensed health care provider and shall not include home exercise programs or over-the-counter medications.

K.S.A. 44-519 states:

[N]o report of any examination of any employee by a health care provider, as provided for in the workers compensation act . . . shall be competent evidence in any proceeding for the determining or collection of compensation unless supported by the testimony of such health care provider, if this testimony is admissible, and shall not be competent evidence in any case where testimony of such health care provider is not admissible.<sup>26</sup>

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<sup>26</sup> See also K.A.R. 51-3-5a.

K.S.A. 2011 Supp. 44-551(i)(1) provides, in part:

All final orders, awards, modifications of awards, or preliminary awards under K.S.A. 44-534a and amendments thereto made by an administrative law judge shall be subject to review by the board upon written request of any interested party. . . . On any such review, the board shall have authority to grant or refuse compensation, or to increase or diminish any award for compensation or to remand any matter to the administrative law judge for further proceedings.

K.S.A. 2011 Supp. 44-555c(a) provides, in part:

The board shall have exclusive jurisdiction to review all decisions, findings, orders and awards of compensation of administrative law judges under the workers compensation act. The review by the board shall be upon questions of law and fact as presented and shown by a transcript of the evidence and the proceedings as presented, had and introduced before the administrative law judge.

From July 1, 1993 forward, the Board assumed the de novo review of the district court.<sup>27</sup> “It is the function of the [Board] to decide which testimony is more accurate and/or credible, and to adjust the medical testimony along with the testimony of the claimant and any other testimony which may be relevant to the question of disability.”<sup>28</sup>

To establish compensable traumatic neurosis, claimant must prove :

. . . (a) a work-related physical injury; (b) symptoms of the traumatic neurosis; and (c) that the neurosis is directly traceable to the physical injury.<sup>29</sup>

In *Berger*,<sup>30</sup> the Kansas Supreme Court cautioned:

Even though this court has long held that traumatic neurosis is compensable; we are fully aware that great care should be exercised in granting an award for such injury owing to the nebulous characteristics of a neurosis. An employee who predicates a claim for temporary or permanent disability upon neurosis induced by trauma, either scheduled or otherwise, bears the burden of proving by a preponderance of the evidence that the neurosis exists and that it was caused by an accident arising out of and during the course of his employment.

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<sup>27</sup> See *Nance v. Harvey Cnty.*, 263 Kan. 542, 550-51, 952 P.2d 411 (1997).

<sup>28</sup> *Tovar v. IBP, Inc.*, 15 Kan. App. 2d 782, 786, 817 P.2d 212, *rev. denied* 249 Kan. 778 (1991).

<sup>29</sup> *Love v. McDonald's Restaurant*, 13 Kan. App. 2d 397, Syl., 771 P.2d 557, *rev. denied* 245 Kan. 784 (1989).

<sup>30</sup> *Berger v. Hahner, Foreman & Cale, Inc.*, 211 Kan. 541, 550, 506 P.2d 1175 (1973).

While the parties sometimes noted standards of medical “certainty” and “clear and convincing” evidence, the standard of proof to establish a compensable traumatic neurosis is based on a preponderance of the credible evidence.

### **ANALYSIS**

#### **1. Claimant’s “traumatic neurosis” is compensable.**

Respondent argues claimant did not prove a compensable traumatic neurosis because: (A) his 2011 psychological injury solely aggravated, accelerated or exacerbated a preexisting condition; (B) his 2011 accident was not the prevailing factor in his psychological injury, medical condition, and resulting disability or impairment; (C) he did not suffer a traumatic neurosis directly traceable to his physical injury; and (D) Dr. Leahy is not qualified to give opinions and his opinions are unreliable.

##### **A. Claimant’s 2011 injury did not solely aggravate a preexisting condition.**

The Board adopts the rationale of the November 18, 2013 preliminary hearing Order. Claimant proved his injury was not solely an aggravation, acceleration or exacerbation of a preexisting condition. No new evidence on this issue was presented.

Respondent asserts the fact “claimant suffered from the same conditions prior to September 23, 2011 renders his subsequent problems nothing more than an aggravation of a preexisting condition which would not be compensable.”<sup>31</sup> Respondent argues claimant had a “20-year history of psychological problems and treatment”<sup>32</sup> and claimant was “treated for depression, anxiety, stress and insomnia for over 20 years prior to the accident” and was “prescribed antidepressants and antianxiety medications, narcotic pain medication as well as sleep aids immediately prior to the 9/23/11 accident.”<sup>33</sup>

The Board finds claimant had chronic pain and some unknown degree of depression prior to his 2011 injury. However, the Board does not view the evidence as showing claimant’s psychological problems after his 2011 injury were the same as any problems he had beforehand. Claimant did not admit his psychological problems were the same both before and after the 2011 accident. No health care provider gave testimony to that effect.

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<sup>31</sup> Respondent’s Brief (filed Oct. 21, 2013) at 9; see also Respondent’s Submission Letter (filed Oct. 17, 2013) at 8 and Respondent’s Brief (filed Jan. 21, 2014) at 4.

<sup>32</sup> Respondent’s Brief (filed Jan. 21, 2014) at 5.

<sup>33</sup> *Id.* at 4.

The Board does not view claimant as having two decades of preexisting psychological problems. Claimant had two days of alcohol detoxification in 1993 or 1994, he saw or treated with a number of health care providers for depression starting in June 1999 (with no discernable end date), he took Effexor and Klonopin in mid-1999, he had some court-ordered psychological counseling starting in 1999, and he took Zoloft, Paxil and Wellbutrin before his accident, but the record does not establish when or for how long.

While Dr. Woltersdorf observed claimant had issues with depression and stress in 1999, prior to the 2011 accident, claimant's last actual mental health diagnosis – "clinical depression" – was made by Dr. Murati in January 2000. The last record of psychiatric, psychological or mental health treatment is from 1999. Claimant reported chronic spine pain and sleep problems to Dr. Bliss between 2006 and 2011, but Dr. Bliss never diagnosed claimant with depression or generalized anxiety disorder and never diagnosed insomnia. The one mention of stress in Dr. Bliss' records concerns claimant being worried just preceding his 2010 neck surgery, which is understandable.

Dr. Bliss prescribed claimant Cymbalta and amitriptyline, which are antidepressants, but Cymbalta was provided to address claimant's back pain. Claimant later advised Dr. Bliss' office that Cymbalta did not relieve his joint pain, without mention of his psychological status. Dr. Bliss' 2008 phone note, that someone named "Jeff" indicated Cymbalta could be used for chronic pain and/or depression does not prove such drug was prescribed for depression, rather that the drug could be used for alternate purposes. The amitriptyline was prescribed not for depression, but as a sleep aid in place of Ambien.

Before his 2011 injury, claimant took various medications for chronic pain. Dr. Bliss prescribed Neurontin and Robaxin about 6½ months before the 2011 injury. Claimant's relevant post-injury medications include Percocet, alprazolam, Cymbalta, methadone hydrochloride and methylphenidate hydrochloride (Ritalin).<sup>34</sup> A May 20, 2013 pharmacy print-out lists medications back to January 3, 2013, including amitriptyline, Cymbalta, oxycodone-acetaminophen, methadone HCL, alprazolam, Lyrica, bupropion HCL (Wellbutrin) and methylphenidate, all prescribed by Dr. Clarkson.<sup>35</sup> While claimant took some of these medications pre-injury, it does not appear he was taking alprazolam, Lyrica or methadone prior to his 2011 accidental injury. This indicates claimant's pain worsened after the 2011 injury and only then did he need to take anxiety medication, implying the 2011 injury was more than a mere aggravation of a preexisting condition.

There is argument, but no evidence claimant's current psychiatric or brain injury symptoms, impairment or disability are the same as they were pre-injury. Claimant had a TBI as a result of his accident, separate and distinct from any prior degree of depression. The TBI affects his cognition and such injury is not solely an aggravation, acceleration or exacerbation of a preexisting condition.

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<sup>34</sup> P.H. Trans. (June 3, 2013), Cl. Ex. 4 at 1 (Dr. Clarkson's May 8, 2013 letter).

<sup>35</sup> *Id.*, Cl. Ex. 7 at 1.

Respondent argues Dr. Murati opined claimant's 2011 injury resulted in a sole aggravation of preexisting depression because Dr. Murati stated claimant had an aggravation of prior depression. However, no health care professional testified claimant's 2011 injury "solely" aggravated his preexisting mental health problems, or used similar terminology to downplay the impact of the 2011 injury. Similarly, while respondent argues Dr. Harris testified it would be impossible to determine whether claimant suffered more than an aggravation of a preexisting condition without knowing claimant's medical history, Dr. Harris did not opine any psychological injury claimant suffered due to the 2011 accident was solely an aggravation of a preexisting condition. Dr. Harris' "opinion" about whether an aggravation of a preexisting condition occurred is not an opinion, but the absence of an opinion. Dr. Harris, like Dr. Murati, admittedly lacks expertise as a mental health expert.

Finally, the Board rejects respondent's assertion that claimant was required to set forth medical evidence from a physician, as opposed to a psychologist, in order to prove more than a sole aggravation of a preexisting condition. The statute addressing a sole aggravation contains no requirement for proof from a physician instead of a psychologist.<sup>36</sup>

**B. Claimant's accident was the prevailing factor in his psychological injury, need for medical treatment, impairment or disability.**

Claimant proved his 2011 accident was the prevailing factor with respect to his psychological injury, medical condition, resulting disability and impairment. The Board adopts the single Board Member's analysis and conclusions from the November 18, 2013 preliminary hearing Order. The Board adopts Dr. Leahy's opinion.

According to respondent, claimant failed to tell Dr. Harris about his history of psychological problems, chronic pain, sleep disorder and use of medications for such conditions. Respondent notes that, as a result, Dr. Harris testified it would be impossible to establish the 2011 accident was the prevailing factor causing claimant's psychological injury, need for treatment and disability. What Dr. Harris espouses is not an opinion concerning prevailing factor at all, but the absence of an opinion. Dr. Harris' input as to the prevailing factor issue is best paraphrased as, "I don't know." Dr. Harris' lack of an opinion does not undermine claimant's case.

**C. Claimant's traumatic neurosis is directly traceable to his physical injury.**

On this issue, the Board adopts the single Board Member's November 18, 2013 analysis. Based on Dr. Leahy's testimony and reports, the Board concludes claimant proved his traumatic neurosis was directly traceable to his physical injury. No additional evidence regarding Love's directly traceable link was presented.

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<sup>36</sup> The Board also rejects: (1) respondent's assertion claimant must set forth medical evidence from a physician, and not a psychologist, to prove the prevailing factor requirement, and (2) respondent's argument that only a physician may opine that a traumatic neurosis is directly traceable to a physical injury.

As an aside, the Board notes that there may be some overlap between statutory proof that an accident was the prevailing factor in causing an injury and case law requiring that the traumatic neurosis be the direct result of the physical injury. While applying both standards may be duplicative, the Board is required to follow binding precedent.<sup>37</sup>

**D. Dr. Leahy's opinions are valid and credible.**

Respondent contests Dr. Leahy's rating because the *Guides* state a functional impairment rating is only valid if it comes from a physician. Respondent observes use of the *Guides* is required to provide a rating in a Kansas workers compensation claim and the *Guides* state it is a "physician's responsibility" to determine impairment. Therefore, respondent argues only a medical doctor – and not a psychologist like Dr. Leahy – may provide an impairment rating. The Board rejects respondent's specific argument that Kansas law precludes a rating from a psychologist because the *Guides* limit a rating opinion only from a physician. The *Guides* do not supplant Kansas law.<sup>38</sup>

Respondent also challenges Dr. Leahy's functional impairment opinion based on his lack of ownership of a copy of the *Guides*, his lack of understanding of the *Guides*<sup>39</sup> and the fact he never previously provided a rating using the *Guides*. Ownership of the *Guides* is irrelevant. Knowing what the *Guides* are and not having previously provided a rating are not statutory requirements to provide a rating. Such factors could be important if Dr. Leahy's rating was not in accord with the *Guides*, but there is no such evidence.

Respondent also implies Dr. Leahy merely assumed paperwork he was provided to formulate a rating was a copy of a portion of the *Guides*.<sup>40</sup> Whatever Dr. Leahy was given to formulate a rating, such paperwork was in his file. Certainly, had Dr. Leahy used something other than the *Guides* to provide a rating, respondent would have noted such information to the Board.

Respondent further argues Dr. Leahy's opinions were based on a mere assumption claimant's psychological issues were caused by the September 23, 2011 accident. Respondent asserts Dr. Leahy did not have "claimant's five-year history of chronic back pain, anxiety, stress and inability to sleep immediately prior to the September 23, 2011 accident."<sup>41</sup> Respondent is correct that Dr. Leahy did not know about Dr. Bliss' diagnoses or the treatment he rendered, including the medications he prescribed.

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<sup>37</sup> See *Gadberry v. R. L. Polk & Co.*, 25 Kan. App. 2d 800, 808, 975 P. 2d 807 (1998).

<sup>38</sup> See *Redd v. Kansas Truck Center*, 291 Kan. 176, 196-97, 239 P.3d 66 (2010).

<sup>39</sup> Dr. Leahy was asked, "Do you know what the AMA Guides are?" He responded, "In specific terms, no." (Leahy Depo. at 37).

<sup>40</sup> See Respondent's Submission Letter (filed Oct. 17, 2013) at 11.

<sup>41</sup> *Id.* at 7.

While respondent attacks Dr. Leahy's opinions based on what Dr. Leahy did not know, Dr. Leahy was never asked if his opinions would be altered based on information previously unknown to him. In other words, Dr. Leahy was not asked if Dr. Bliss' records (which contain no mental health diagnoses or fair inference claimant was taking medication for depression) affected his opinions.

Respondent further argues Dr. Leahy: (1) failed to confirm the validity of claimant's psychological complaints through testing and (2) ignored Dr. McDaniel's testing and "elected not to obtain the underlying test data which established that claimant was not giving a valid effort, was not cooperating, was consciously trying to deceive the evaluator and was malingering."<sup>42</sup> However, there is no legal requirement that Dr. Leahy conduct psychological testing. Dr. Leahy's role was as a treating psychologist. He had no duty to conduct psychological testing or obtain test results from any other health care provider. There is no evidence Dr. Leahy ignored Dr. McDaniel's opinion or decided to not pursue obtaining her raw testing data. Rather, Dr. Leahy was critical of Dr. McDaniel's opinions and was "confused and baffled" regarding her conclusion that claimant was malingering.<sup>43</sup>

Respondent cites Dr. McDaniel's opinions in its brief, but agreed at oral argument that Dr. McDaniel's report is not in evidence. Medical reports may be considered as evidence when the parties agree,<sup>44</sup> but claimant objected to introduction of Dr. McDaniel's report. K.S.A. 44-519 precludes Dr. McDaniel's report from being part of the evidence.

**2. Due to his 2011 accidental injury, claimant has a 49% whole body impairment and is permanently and totally disabled.**

*TBI/Depression*

The evidence establishes claimant has permanent functional impairment due to his TBI. Dr. Murati provided claimant a 14% whole body impairment based on a closed head injury, while Dr. Harris gave claimant a 3% whole body impairment for "mental status/brain injury" and a 2% whole body rating for emotional and behavioral disorders. Dr. Leahy, using materials from the *Guides* supplied to him by claimant's attorney, provided claimant with a 10% whole body rating for cognitive impairment and a 20% whole body rating for emotional/behavioral impairment.

The Board concludes claimant's head injury caused a 9% whole body impairment for TBI/mental status/cognitive impairment. The Board finds claimant's overall whole body impairment for emotional disorders is 11%, as based on an average of the opinions.

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<sup>42</sup> *Id.* at 7.

<sup>43</sup> Leahy Depo. at 14; see also pp. 16-20.

<sup>44</sup> K.A.R. 51-3-5a; see *Kirker v. Bob Bergkamp Construction Co., Inc.*, No. 107,058, 286 P.3d 576 (Kansas Court of Appeals unpublished opinion filed Oct. 12, 2012), where a prior settlement hearing transcript and the attached medical reports were offered into evidence without objection.

Respondent requests a credit, arguing Dr. Harris opined claimant had a 5% preexisting impairment for his psychological condition.<sup>45</sup> The Board does not view Dr. Harris' report or testimony as supporting respondent's position.

### Cervical Spine

Claimant's cervical spine impairment due to his September 23, 2011 accidental injury is an additional 15% to the body as a whole over his preexisting impairment. The Board adopts Dr. Harris' 15% whole body rating over Dr. Murati's 25% whole body rating.

The SALJ's Award did not give respondent a credit for preexisting impairment. Claimant had a prior 20% cervical spine impairment based on Dr. Prostic's opinion. No other physician provided a contrary opinion. Based on K.S.A. 2011 Supp. 44-501(e), respondent is entitled to a credit for such 20% preexisting functional impairment.

Claimant's argument that a credit for preexisting impairment does not apply is rejected. K.S.A. 44-510a, which claimant cites, was repealed before his accidental injury. The version of K.S.A. 44-501(c), to which claimant refers relative to the *Lyons*<sup>46</sup> case, was amended. Also, claimant's argument that his September 23, 2011 injury only involved C4-5, and did not aggravate C5-7, is misplaced because his own expert, Dr. Murati, testified that all three levels were involved in the new injury.<sup>47</sup>

### Carpal Tunnel Syndrome

Dr. Prostic noted claimant had persistent bilateral upper extremity sensory difficulties after his 2010 cervical spine surgery. The Board finds unrealistic Dr. Murati's conclusion that claimant developed bilateral CTS due to his 2011 accidental injury. Claimant's bilateral upper extremity symptoms are unrelated to the 2011 injury.

### Shoulder/Brachial Plexus

Dr. Murati gave claimant a 52% left upper extremity rating (which included unrelated CTS) and Dr. Harris gave a 23% left upper extremity rating. The Board concludes claimant has a 14% left upper extremity impairment for decreased shoulder range of motion, and a brachial plexus impairment of 25% (22% for the axillary nerve combined with 3% for the radial nerve combined with 1% for the subscapularis nerve) for a combined left upper extremity impairment of 36% at the level of the shoulder. A 36% rating to the upper extremity at the level of the shoulder converts to 22% to the body as a whole.<sup>48</sup>

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<sup>45</sup> Respondent's Brief (filed Jan. 21, 2014) at 8.

<sup>46</sup> *Lyons v. IBP, Inc.*, 33 Kan. App. 2d 369, 378, 102 P.3d 1169 (2004).

<sup>47</sup> Murati Depo. at 46.

<sup>48</sup> *Guides* at 20 (Table 3).

Vestibular Disorder, Trigeminal Neuropathy and Mastication

Dr. Murati opined claimant had whole body impairment from vestibular disorder due to loss of balance (5%), trigeminal neuropathy (3%) and mastication (5%). Dr. Murati's opinions regarding these three impairments could be viewed as not being contradicted, and at least based on case law, presumptively valid.<sup>49</sup> Of the three, the Board accepts the mastication impairment as valid, as claimant had a jaw injury and testified regarding teeth injuries that have caused ongoing problems.

The Board cannot find other medical evidence or claimant's testimony suggesting claimant has impairments due to dizziness or cranial nerve dysfunction. Neither Dr. Harris nor Dr. Henderson identified such problems. Dr. Henderson noted claimant had no disorientation and Romberg testing was negative, while Dr. Harris noted claimant's cranial nerves were intact. Only Dr. Murati found vestibular disorder and trigeminal neuropathy impairments. The Board declines to conclude claimant is impaired from such conditions.

Overall impairment and other potential preexisting impairment

Respondent seeks a credit based on claimant's preexisting lumbar impairment. Claimant has no lumbar impairment associated with his current claim. The Board concludes reducing the award by unrelated preexisting lumbar impairment is inappropriate.

Claimant's total whole body impairment as a result of his September 23, 2011 accident is 49% consisting of:

	22% left shoulder
combined with	<u>15% cervical spine</u>
	34%
combined with	<u>11% psychological</u>
	41%
combined with	<u>9% TBI</u>
	46%
combined with	<u>5% mastication</u>
	49% whole body impairment <sup>50</sup>

Deducting claimant's 20% preexisting cervical impairment from the 49% impairment occasioned by his 2011 accident results in claimant being entitled to permanent partial disability benefits based on a resulting 29% functional impairment to the body as a whole.

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<sup>49</sup> See *Anderson v. Kinsley Sand & Gravel, Inc.*, 221 Kan. 191, 558 P.2d 146 (1976).

<sup>50</sup> As noted in footnote 1, the impairments are not simply added together, but combined using the Combined Values Chart in the *Guides*.

Claimant is permanently and totally disabled.

In *Wardlow*,<sup>51</sup> the Kansas Court of Appeals indicated a worker being “essentially and realistically unemployable” was compatible with him being permanently and totally disabled under K.S.A. 1992 Supp. 44-510c(a)(2). Respondent, citing *Nelson*, argues that it must be impossible for a claimant to work to receive permanent total disability benefits. However, subsequent to *Nelson*, the Kansas Court of Appeals has favorably cited or used the “essentially and realistically unemployable” standard from *Wardlow*.<sup>52</sup>

Ms. Terrill, who never interviewed claimant, testified claimant could engage in substantial and gainful employment. Dr. Harris agreed, although he never provided any work restrictions.<sup>53</sup> According to Dr. Murati and Paul Hardin, claimant is unable to engage in substantial and gainful employment.

Respondent contends such opinions are unreliable and at least partially based on claimant’s unrelated preexisting lumbar fusion, a preexisting cervical fusion, CTS and preexisting depression and pain syndrome, in addition to prior work restrictions. Respondent observes that permanent total disability must be “on account of the injury.”<sup>54</sup> Respondent is correct that Dr. Murati’s restrictions are at least in part based on claimant’s preexisting low back and non-compensable bilateral CTS.<sup>55</sup> As such, his opinion seems to be based not on account of the injury, but on account of the 2011 injury and the 1998 low back injury, subsequent low back surgeries and unrelated CTS. Mr. Hardin’s opinion that claimant was permanently and totally disabled was based on Dr. Murati’s restrictions.

In spite of Dr. Murati partially basing his permanent total disability opinion on unrelated impairment or prior injury, the Board nonetheless finds that claimant is permanently and totally disabled. Claimant is completely and permanently incapable of engaging in any type of substantial and gainful employment, as based on the total evidence, including his physical, cognitive and emotional impairments, as well as his extensive restrictions.

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<sup>51</sup> *Wardlow v. ANR Freight Sys.*, 19 Kan. App. 2d 110, 113, 872 P.2d 299 (1993).

<sup>52</sup> See *Conrow v. Globe Eng'g Co., Inc.*, 43 Kan. App. 2d 827, 830-31, 231 P.3d 1080 (2010); *Poff v. IBP, Inc.*, 33 Kan. App. 2d 700, 705, 106 P.3d 1152 (2005); *Lyons v. IBP, Inc.*, 33 Kan. App. 2d 369, 378, 102 P.3d 1169 (2004); and *Henson v. Belger Cartage Services, Inc.*, No. 107,026, 2012 WL 3000389 (Kansas Court of Appeals unpublished opinion filed July 20, 2012, rev. denied Sept. 4, 2013).

<sup>53</sup> Respondent also notes Drs. Grundmeyer and Henry opined claimant was able to return to work, but their reports are not in evidence. They did not testify and claimant's attorney objected to their opinions.

<sup>54</sup> Respondent’s Submission Letter (filed Oct. 17, 2013) at 10.

<sup>55</sup> Examples include bilateral use of wrist splints and no bilateral use of vibratory tools for his upper extremities, as well as avoiding twisting the trunk and no bending, crouching or stooping, which appear to concern claimant’s low back.

Respondent is entitled to a reduction for claimant's preexisting impairment. Following the *Payne*<sup>56</sup> methodology to determine a credit for a preexisting disability in a permanent total disability (PTD) case, the reduction is based on:

1. calculating the number of weeks a \$155,000 PTD award would be paid out using the applicable compensation rate of \$555, which is 279.28 weeks;
2. calculating the number of weeks it takes to pay permanent partial disability (PPD) at the same rate based on the preexisting 20% whole body functional impairment, which is 83 weeks;
3. subtracting 83 weeks from 279.28 weeks, or 196.28 weeks; and
4. multiplying 196.28 weeks by the \$555 weekly compensation rate, the product of which, \$108,935.40, is the PTD claimant is entitled to receive, less amounts previously paid.

### **3. Claimant is entitled to future medical.**

SALJ Shelor impliedly left future medical open by stating future medical benefits would be awarded upon application to and approval by the Director of the Division of Workers Compensation.

Dr. Harris agreed that people with brain injuries benefit from medication and claimant may benefit from continued treatment and therapy. Dr. Leahy indicated claimant will require psychiatric medicine and supportive therapy. Dr. Murati recommended claimant have at least yearly examinations for his neck, upper back, low back, bilateral upper extremities and head in the event of "complications that may ensue."<sup>57</sup>

At first glance, Dr. Murati's opinion seems somewhat speculative, but at a minimum, yearly follow-up appointments for an individual who had a cervical spine fusion and left shoulder surgery makes sense. Claimant also has heterotopic ossification about the left shoulder, as identified by Dr. Harris and termed "bony growths" in the neck, clavicle and shoulder region by Dr. Henderson.<sup>58</sup> Dr. Henderson noted claimant's complaint that such growths were pressing on claimant's esophagus, causing him difficulty with swallowing. Moreover, the medical evidence demonstrates claimant will need ongoing treatment. Claimant has been regularly taking prescribed medication for his injuries and is treating with Dr. Clarkson and Dr. Leahy. The medical evidence establishes, more probably true than not, that additional medical treatment will be necessary after claimant reached maximum medical improvement.

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<sup>56</sup> *Payne v. Boeing Co.*, 39 Kan. App. 2d 353, 180 P.3d 590 (2008).

<sup>57</sup> Murati Depo., Ex. 2 at 10.

<sup>58</sup> Leahy Depo., Ex. 3 at 1.

Claimant is entitled to seek future medical treatment on proper application to the Division of Workers Compensation. Claimant is not awarded medical treatment for conditions unrelated to his case, such as his low back or purported CTS.

### **CONCLUSIONS**

The Board concludes:

1. claimant proved a compensable psychological injury;
2. claimant has a 49% whole body functional impairment rating due to his September 23, 2011 accidental injury;
3. respondent is entitled to a reduction in the form of a credit for claimant's 20% preexisting impairment rating due to his prior cervical spine condition;
4. claimant is permanently and totally disabled as a result of his September 23, 2011 accidental injury;
5. as agreed by the parties, respondent gets credits for prior PPD and retirement payments; and
6. claimant is entitled to future medical treatment.

### **AWARD**

**WHEREFORE**, the Award is modified as listed above in the "Conclusions" section. Claimant is entitled to a permanent total disability award totaling \$108,935.40 (reduced from \$155,000 based on a 20% preexisting impairment following *Payne*), less the \$26,363.67 paid in TTD benefits, the \$8,325 paid in PPD benefits, and the \$1,018.81 reduction for retirement benefits.

As of April 25, 2014, claimant is entitled to a total due and owing of \$74,925, which is ordered paid in one lump sum less amounts previously paid for TTD, PPD and respondent's credit for retirement benefits, or a resulting amount due and owing of \$39,217.52. Thereafter, the remaining balance in the amount of \$34,010.40 shall be paid at the rate of \$555 per week until fully paid or until further order.

**IT IS SO ORDERED.**

Dated this \_\_\_\_ day of April 2014.

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BOARD MEMBER

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BOARD MEMBER

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Honorable John Clark

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